

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (123)

## CERTIFICATE OF DEATH

Reg. Dist. No. 50 87

## 1. PLACE OF DEATH:

County Calvert CountyCity or town Solomons, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn. CountyCity or town Wilkes-Barre  
(If outside city or town limits, write RURAL and give nearest town)Street No. 262 1/2 Lee Park Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war World War II ✓

## 3. (a) FULL NAME

BAILEY, Larry Cowden Slc V-6 USNR SV #921-65-93

## 3. (b) Social Security Number

- - - -

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Viola M. Bailey7. Birth date of deceased (mo., day, yr.) 23 April 1918

6. (c) If alive, give age years

8. AGE: Years 27 Months 4 Days 13 If less than one day  
.....hrs. ....min.9. Birthplace W. Carrollton, Ohio  
(Town, county, and state)10. Usual occupation U.S. Navy11. Industry or business U.S. Navy12. Name Unknown

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant U.S.N.

Address

17. Burial Date thereof 9-10-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington National CemeteryLocation Fort Meyers, Virginia18. Funeral director J.B. RobinsonAddress Leonardtown Md.19. 9/18 19 45 Canalier  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 September 19 45 at 11:15A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
.....19....., to.....19.....

and that I last saw h.....alive on.....18.....

Immediate cause of death Drowning DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results Death by drowning

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....

J. T. SMITH, Lt. (MO) D. or other USN.  
Address USNMWTS Dispensary, Solomons Date signed 9-7-45

CERTIFICATE OF DEATH

GEORGE A. BUREAU  
OCT 3 1945

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(1572)

08866

52

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Cabaret  
 City or town... Prince Frederick  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
 Hospital, institution, or street address where death occurred.....  
Hospital

How long in hospital or institution?.....

## 3. (a) FULL NAME

Leonard Baby Boy Del Vecchio

## 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

m. W

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... 6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... It less than one day..... hrs. .... min.

9. Birthplace.....  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... Leonard Del Vecchio

13. Birthplace..... Washington D C

14. Maiden name..... Pauline Lucas

15. Birthplace..... Shenandoah

16. Informant..... Leonard Del Vecchio

Address..... North Beach Md

17. Burial Date thereof..... 9/14/45  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Cemetery

Location..... mt Harmony

18. Funeral director..... Wm H. Hutchins

Address..... Owings Md.

19. Sept 14 19 45 W H Hutchins  
 (Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 9/14 19 45 at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/14 19 45 to 9/14 19 45

and that I last saw him alive on 9/14/45 19 45

Immediate cause of death.....

Congenital heart

DURATION

1 hr

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Howard  
Owings Md  
 Address..... Date signed.....

M. D. or other

RECEIVED  
OCT 8 1945  
BUREAU V.B.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 287

## 1. PLACE OF DEATH:

County CalvertCity or town Salemans, Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia CountyCity or town Covington Virginia (RR #2)  
(If outside city or town limits, write RURAL and give nearest town)Street No.  
(If rural, give LOCATION)

2.(c) If veteran, name war

## 3.(a) FULL NAME

PERSINGER, John Marion

## 3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

11-9-22

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

22104

hrs.

min.

9. Birthplace Covington, Va.

(Town, county, and state)

10. Usual occupation

Sailor, U.S. Navy

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Edith Pearl Persinger

15. Birthplace

16. Informant

Address

17. Removal  
(Burial, cremation, or removal. Which?)

Date thereof

9/15/45  
(month) (day) (year)

Cemetery or crematory

Location

Covington, VA.

18. Funeral director

Address

19. 9/15  
(Date rec'd by registrar)

1945

Cummins

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 13 September 1945, at 1130 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death Drowning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Body decomposed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11 Sept 45Where did injury occur? Salemans, Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Patuxent River

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 45 N W WTS Salem Md Date signed 9-14-45

RECEIVED  
OCT 3 1945  
BUREAU OF